APPENDIX A

SUMMARY OF THE HERITAGE PROPOSAL

The summary of the Heritage proposal that follows was provided by Stuart Butler, Vice President and Director of Domestic and Economic Policy Studies for the Heritage Foundation, in response to a query from the Congressional Budget Office. It is reproduced here verbatim.

The Heritage Foundation

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April 8, 1994

Dr. Linda Bilheimer
Deputy Assistant Director for Health
Congressional Budget Office
419C Ford House Office Building
Washington, D.C. 20515

Dear Dr. Bilheimer,

As we have discussed by telephone, The Heritage Foundation has changed certain aspects of our Consumer Choice Health Plan since the series of documents we published earlier. In general -- though not in every detail -- these changes are reflected in the relevant parts of the Consumer Choice Health Security Act of 1993, introduced in the Senate by Senator Don Nickles and in the House by Congressman Cliff Stearns. I am pleased to provide in summary form the Heritage proposal as it is today. For your analysis you should assume the Heritage Plan is identical to the relevant Nickles provisions except where noted. There are some differences between the Senate and House versions of the legislation -- confined, I believe, to the Medicare and Medicaid funding provisions. You should take the Senate language as being most similar to our thinking.

Sincerely,

Stuart M Butler

Stuart Butler, Ph.D.
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Implementation

* The proposal would take effect January 1, 1997.

Health Care Expenses Tax Credit

* Anyone covered by a federally qualified health insurance plan would be eligible to receive a refundable tax credit that would depend on the individual's or family's unreimbursed health care expenses as a percentage of adjusted gross income (AGI). These expenses would comprise qualified premiums and eligible medical care expenses. "Federally covered" individuals (see below) would not be eligible for the credit. The credit would be calculated on the following schedule:

  - For that portion of expenses up to 10% of AGI, 25%;
  - For that portion of expenses between 10% and 20% of AGI, 50%;
  - For that portion of expenses exceeding 20% of AGI, 75%.

  For people covered by a federally qualified plan only part of the year, the amount of the credit would be prorated according to the number of whole months in which the individual was covered.

* A 25% credit would be available for contributions to a medical savings account, to be used only for medical purposes. We do not anticipate, at least in the early years after enactment, that a large number of these accounts would be created, and so our calculations of the impact of the plan on specific families assumes a credit is used only for insurance and direct out-of-pocket expenses. Over several years, however, we would expect the number of such accounts to grow.

* All employers would be responsible for advancing to the employee the estimated amount of the employee's health tax credit; all employers would also have to withhold money for the employee's premium and remit it to the plan. Employers who did not comply could be subject to a tax of $50 per day per employee.

  Please note, there is a drafting error in §101(b) of the bill, which specifies that the advance would cover anticipated premiums for the federally qualified health insurance plan, not qualified premiums (which also would include premiums for supplementary or richer plans). This is unintentional and will be corrected.

* Medical care would be defined broadly to include services related to preventing, diagnosing and treating illness and injury, including related transportation services subject to reasonable limits. Expenses for cosmetic surgery and non-prescription drugs would not count toward the credit. Neither would expenses for the care of dependents be eligible if those expenses were allowable under §21 of the tax code.

* Both premiums paid for the federally qualified plan and for plans that supplemented the federally qualified plan would count in calculating the credit. That is, premiums for supplemental plans or for a plan with more generous coverage than the federal minimum would count if they covered the same set of services as the federally qualified plan. Premiums would not count toward the credit to the extent they covered long-term care. Thus, the intention in The Heritage Plan (and the Nickles bill) is that dental care and dental benefits would be eligible for the credit, but that long-term care (that is, nursing home costs) would not, unless the services qualified as "appropriate alternatives to hospitalization."

<u>Other Health-related Tax Provisions</u>

* The following existing tax provisions would be repealed:

  - The exclusion from taxable income of employer contributions to employees' health insurance plans.

  - The deduction allowed for medical expenses that exceed 7.5% of AGI.

  - The deduction allowed to self-employed people whereby they may deduct 25% of the cost of their health insurance from their total income reported for tax purposes.

  - The earned income tax credit for health insurance.

  - The tax deduction for the self-employed and the health insurance portion of the EITC are both scheduled to expire soon. Both Heritage and the sponsors of the legislation neither propose to extend those provisions beyond their current expiration dates, nor propose to prevent their extension by other legislation up to January 1, 1997, when the new tax credits take effect.

- The tax exclusion for cafeteria-type plans under §125 of the tax code would be changed. Funds for health spending could no longer be included in such tax-free accounts, but instead employees would gain a credit for contributions to their own medical savings account, which would not be subject to the rollover restrictions and other limitations associated with flexible spending accounts or cafeteria plans.

Individual Mandate

* All U.S. citizens and permanent residents would have to be covered by a federally qualified health insurance plan. This requirement would not apply to "federally covered" individuals, who would comprise those covered by Medicare, Medicaid, the military health services system, the Department of Veterans Affairs, and the Indian Health Service.

* States would have the responsibility of identifying residents who refused to purchase the required minimum coverage and enrolling them in a federally qualified plan. (See section on state role below.)

  Please note that we at Heritage have recommended a somewhat different form of enforcement, and in this case "The Heritage Plan" differs from the Nickles-Stearns bill. Under the Nickles Bill, people who did not arrange coverage for themselves--either through the government programs listed above or by buying a federally qualified plan--would be ineligible to claim any exemptions when calculating taxes payable.

  The Heritage proposal does not include the denial of the personal exemption as a penalty for failure to obtain the required minimum coverage. We propose instead that employers be required to report to the state workers who are unable or unwilling to demonstrate proof of minimum coverage for themselves and/or their dependents. This would assist states in identifying such individuals. The sponsors of the legislation did not want to place this burden on employers and instead included the provision denying the personal exemption to those who refuse to purchase coverage.

  In our view, under the legislation, it would still be possible for states to impose a reporting requirement on employers if they so choose.

  Please note there is a drafting error in §103(a)(1) of the bill. As drafted, the bill would inadvertently deny exemptions to federally covered individuals. This will be corrected.

Federally Qualified Health Insurance Plan

* To be a federally qualified health plan, a plan would have to have at least the following features:

  - Cover all medically necessary acute care services, including at minimum: physician services; inpatient, outpatient, and emergency hospital services; appropriate alternatives to hospitalization; and inpatient and outpatient prescription drugs.

  - Not exclude selected illnesses or selected, medically accepted treatments.

  - Deductible of no more than $1,000 for an individual policy or $2,000 for a family policy, adjusted after 1997 for inflation.

  - "Stop-loss" limit of $5,000 per policy (i.e., same for individual and family policies), adjusted after 1997 for inflation.

* Such a plan would be subject to the following underwriting restrictions:

  - Premiums could vary only with the age, sex, and geographic location of the policyholder.

  - Premiums charged to new and existing policyholders of the same demographic characteristics would have to be identical.

  - Discounts could be given, subject to regulatory approval, if the discounts were designed to promote health, prevent illness, or allow the early detection of illness.

  - Marketing and relating administrative costs would not be considered part of the premium for the purposes of regulatory enforcement of the underwriting and rating restrictions. Thus it would be permissible for an insurer to give "wholesale purchase" discounts to groups of buyers.

  - Guaranteed issue.

  - Guaranteed renewal, except in cases of fraud, misrepresentation, or nonpayment of premiums.

- In 1997, a plan could not limit coverage for pre-existing medical conditions. This is to give the currently uninsured an initial, one-year "window" in which to obtain coverage without regard to their health status. After 1997, a plan could limit coverage of preexisting medical conditions for "X" months, where "X" is the number of months that the applicant was uninsured immediately prior to the date of application. "X" could not exceed 12 months.

- A plan could not offer incentives or disincentives to its agents that encouraged agents to enroll policyholders expected to be relatively low-cost to the plan.

State regulatory authorities would certify which plans were federally qualified. If a state did not meet federal standards for carrying out this certification function, the federal government could take it over for plans in that state.

Transition from Current Insurance Arrangements

* The insurer of a employment-based plan would have to offer existing policyholders (e.g., as of October 1, 1996) the right to convert to a new plan on January 1, 1997. This requirement would apply regardless of whether the plan was self-insured. The new plan would have to offer benefits at least actuarially equivalent to the previous plan, and premiums would have to be set so they varied only with age, sex, and geography. The sum of premiums under the new plan could not exceed the group's total premium on the last day the previous policy was in effect. Insurers who did not comply would be subject to a tax equalling 50% of premium revenue.

  Please note, the bill refers to "employer-sponsored" plans, while at Heritage we use "employment-based" plans as a broader category to also include union-sponsored plans and Taft-Hartley plans. We believe the intention of the Nickles-Stearns legislation is to include such plans as well.

* Any employer sponsoring a self-insured plan that wanted to transfer responsibility for the plan to another party would have to receive the agreement of two-thirds of the plan's primary enrollees. Employers now operating self-insured plans would become subject to all laws pertaining to insurers.

* Each employer now contributing to an employee's health insurance plan would have to "cash out" the plan by increasing each employee's cash wages by an amount in line with the employee's age, sex, and geographic location. Employers who did not comply would be subject to a tax of $50 per day per employee. For federal employees, a commission would be set up to study how to cash out FEHBP benefits and adjust pay scales and retirement benefits accordingly. The reason for this special provision for the FEHBP is that federal pay scales are set by law and congressional action is needed. Further, federal workers with the same base pay may receive different compensation because of the way FEHBP benefits are calculated. The commission's purpose would be to figure out an equitable solution to this special cashing out problem, which would then become an amendment to the law on federal pay.

* Employers could not compel employees to join a plan picked by the employer.

* Each employer would have to hold the employee harmless for the "employer" share of payroll taxes that would become payable on the increase in the employee's taxable income.

<u>State Role</u>

* As a condition of receiving federal funding for health programs, both for entitlement programs and from appropriated funds, states would be responsible for identifying people who were not federally covered and did not purchase a federally qualified health insurance plan. States would have to arrange coverage for these people at least as generous as the federally qualified plan, but could charge premiums that reflected the cost of coverage and the individual's ability to pay. States could meet this responsibility through a new program or through an existing program such as Medicaid.

* States would set up a new program designed to assist people with incomes below 150% of poverty who were ineligible for Medicaid, were eligible for the health tax credit, and for whom premiums and medical expenses exceeded 5% of AGI even after the tax credit was taken into account. States could use funds in this program to assist eligible individuals with supplemental vouchers for purchasing health insurance or by paying for services such as primary and preventive care, emergency transportation, trauma care systems, operating clinics and so forth. Federal funding for the new program would roughly equal expected federal contributions under the Medicaid program to "disproportionate share hospitals" (DSH); the DSH program would be repealed. The federal government would transfer $14.2 billion to the

states in the 1997 fiscal year, with the state-by-state allocation depending on each state's share of the needy population, as defined. States would maintain current efforts through matching payments to the new program.

Please note, based on preliminary estimates, we expect these funds would permit states to reduce direct health spending by members of the target population to about 10% of gross income. We expect that states would in most cases provide assistance in the form of a supplemental voucher, although it could be in other forms, such as free or subsidized clinics.

* State laws would be preempted if they:

  - required health insurance policies to cover specific diseases, services, or providers; or
  - restricted the ability of managed care plans to selectively contract with providers or to impose different levels of cost-sharing on enrollee claims for treatment by providers outside the plan; or
  - restricted insurers' ability to require cost-sharing.

Financing

Please note that at Heritage we are not explicitly wedded to a particular method of financing the difference between the cost of the new tax credit and low income subsidy and the value of the existing tax exclusion. But we are comfortable with the method used in the Nickles bill, as set out below. The House version, as I noted earlier, differs slightly from the Senate measure.

* In addition to the increased revenues that would result from repealing the tax provisions discussed above and from repealing Medicaid DSH payments, the proposal also includes revenue-raising measures affecting the Medicare and Medicaid programs.

* The growth in Medicare spending would be less than it otherwise would have been, due to such measures as eliminating Medicare DSH payments; reducing the adjustment for indirect medical education; imposing copayments on laboratory services, certain home health visits, and skilled nursing facility services; shifting hospital payment updates to January from October; and accelerating the transition to prospective rates for facility costs on outpatient services.

* In a major change for the Medicaid program, the federal contribution to the acute care portion of the program would be capped, with the federal government also easing the requirements for states to receive waivers to establish

innovative and cost-effective programs. The effect of this provision would be to recoup to the federal government most, but not all, of the savings and revenue increases that would accrue to the states under the plan.

* Neither our plan nor the Nickles bill would affect Medicaid long term care.

APPENDIX B

ALTERNATIVE ILLUSTRATIONS OF FINANCIAL IMPACTS

The discussion on pages 36-42, which illustrates the possible financial impacts on various types of families, assumed that under current law each family had the same level of out-of-pocket spending on health care. This assumption was made in order to focus attention on the different impacts that the two proposals would have on families in different situations. In fact, however, out-of-pocket spending varies systematically with variables such as income, insurance coverage, and health status. This appendix therefore provides the interested reader with illustrations that are perhaps more realistic than those in the text, albeit at the cost of increased complexity in the numbers. Regardless of which tables are considered, the qualitative comments made in the text hold true.

The out-of-pocket spending estimates under current law that are shown in Tables B-1 to B-3 reflect CBO's tabulations of data from the 1987 National Medical Expenditure Survey. Most estimates were averages for families of at least three members, all of whom were under 65 years old and had private insurance throughout the year. Families were grouped by income and relative risk, with risk groups defined using the survey's questions on health status as proxies for risk level. Those families reporting good or excellent health status for all members were grouped as "lower risk"; those families in which any member reported poor health status were "higher risk"; and all other cases, including families who reported fair health status, were classified as "average risk." Furthermore, Table B-2 includes an estimate that reflects average out-of-pocket spending by all families that were without insurance during the year, were in the middle-income and average-risk groups, and had no members 65 years old or older. Since the survey reflected 1987 spending patterns, the estimates were inflated to 1991 dollars using the growth in out-of-pocket spending per person from the national health accounts.

The change in out-of-pocket spending under either proposal is very difficult to predict, especially at the level of detail shown in the tables. Accordingly, these tables arbitrarily follow the tables in the text by assuming that spending on out-of-pocket care and supplementary premiums would be 45 percent higher if the proposals were implemented than under current law. The only exception is the uninsured family shown in Table B-2; since it is uninsured under current law and would have insurance with a high deductible in these illustrations under either proposal, its out-of-pocket spending is shown as unchanging.

TABLE B-1. ALTERNATIVE ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS, BY INCOME OF FAMILY (In dollars)

	Income		
	Lower	Middle	Higher
Current Law			
Income Reported for Tax Purposes	21,000	38,000	55,000
Plus nontaxable premiums	3,140	3,140	3,140
Less income and payroll taxes	-2,940	-6,790	-11,690
Less total premium	-3,690	-3,690	-3,690
Less out-of-pocket spending	-830	-900	-1,910
Equals total compensation less taxes and health expenses	16,680	29,760	40,850
Heritage Proposal			
Income Reported for Tax Purposes	24,140	41,140	58,140
Less income and payroll taxes	-3,640	-7,490	-12,610
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,200	-1,310	-2,770
Plus health tax credit	1,630	1,250	1,560
Equals total compensation less taxes and health expenses	17,680	30,340	41,070
Difference from Current Law	1,000	580	220
Pauly Group Proposal			
Income Reported for Tax Purposes	24,140	41,140	58,140
Less income and payroll taxes	-3,640	-7,490	-12,610
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,200	-1,310	-2,770
Plus health tax credit	2,080	910	0
Equals total compensation less taxes and health expenses	18,130	30,000	39,510
Difference from Current Law	1,450	240	-1,340

SOURCE: Congressional Budget Office.

TABLE B-2. ALTERNATIVE ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS, BY CURRENT INSURANCE STATUS OF FAMILY (In dollars)

	Employer Purchase	Individual Purchase	Uninsured
Current Law			
Income Reported for Tax Purposes	38,000	38,000	38,000
Plus nontaxable premiums	3,140	0	0
Less income and payroll taxes	-6,790	-6,360	-6,790
Less total premium	-3,690	-4,780	0
Less out-of-pocket spending	-900	-900	-1,010
Equals total compensation less taxes and health expenses	29,760	25,960	30,200
Heritage Proposal			
Income Reported for Tax Purposes	41,140	38,000	38,000
Less income and payroll taxes	-7,490	-6,790	-6,790
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,310	-1,310	-1,010
Plus health tax credit	1,250	1,330	1,180
Equals total compensation less taxes and health expenses	30,340	27,980	28,130
Difference from Current Law	580	2,020	-2,070
Pauly Group Proposal			
Income Reported for Tax Purposes	41,140	38,000	38,000
Less income and payroll taxes	-7,490	-6,790	-6,790
Less total premium	-3,250	-3,250	-3,250
Less out-of-pocket spending and supplementary premiums	-1,310	-1,310	-1,010
Plus health tax credit	910	1,130	1,130
Equals total compensation less taxes and health expenses	30,000	27,780	28,080
Difference from Current Law	240	1,820	-2,120

SOURCE: Congressional Budget Office.

TABLE B-3. ALTERNATIVE ILLUSTRATION OF POSSIBLE IMPACTS OF PROPOSALS, BY RELATIVE RISK LEVEL OF FAMILY (In dollars)

	Relative Risk Level		
	Low	Average	High
Current Law			
Income Reported for Tax Purposes	38,000	38,000	38,000
Plus nontaxable premiums[a]	1,860	3,140	4,440
Less income and payroll taxes	-6,790	-6,790	-6,790
Less total premium[a]	-2,410	-3,690	-4,990
Less out-of-pocket spending	-1,040	-900	-1,370
Equals total compensation less taxes and health expenses	29,620	29,760	29,290
Heritage Proposal			
Income Reported for Tax Purposes	39,860	41,140	42,440
Less income and payroll taxes	-7,200	-7,490	-7,790
Less total premium[b]	-2,120	-3,250	-4,390
Less out-of-pocket spending and supplementary premiums	-1,500	-1,310	-1,980
Plus health tax credit	900	1,250	2,130
Equals total compensation less taxes and health expenses	29,940	30,340	30,410
Difference from Current Law	320	580	1,120
Pauly Group Proposal			
Income Reported for Tax Purposes	39,860	41,140	42,440
Less income and payroll taxes	-7,200	-7,490	-7,790
Less total premium[b]	-2,120	-3,250	-4,390
Less out-of-pocket spending and supplementary premiums	-1,500	-1,310	-1,980
Plus health tax credit	c	910	c
Equals total compensation less taxes and health expenses	c	30,000	c
Difference from Current Law	c	240	c

SOURCE: Congressional Budget Office.

a. Assumes that the value of insurance varies with risk level; as well, each family is assumed to pay the same amount ($550) toward its premium.

b. For purposes of this table, the range of premiums is assumed to be the same under both proposals.

c. Cannot be estimated from information available.